NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Bartholomew Ryan, an inmate of the Nassau County Correctional Center	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Sheriff Michael Sposato
Nassau County Correctional Center
100 Carman Avenue
East Meadow, NY 11554

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Bartholomew Ryan who died on February 24, 2012 while an inmate in the custody of the Nassau County Sheriff at the Nassau County Correctional Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Bartholomew Ryan was a 32 year old white male who died on 2/24/12 from suicidal hanging while in the custody of the Nassau County Sheriff at the Nassau County Correctional Center. Ryan suffered [redacted] for which he received inadequate evaluation and treatment by Armor Correctional Health Care, Inc. (Armor, Inc.), a business corporation holding itself out as a medical care provider.

2. Bartholomew Ryan was born 5/19/79 and resided in Long Island, NY. Ryan had served in the United States Marine Corp from 2003 to 2008 and served in Iraq. [redacted] He worked as a mechanic and resided most recently at his mother's residence.

3. [redacted]

4. In the instant offense, Ryan was arrested on 2/22/12 for DWI-drugs. He was arraigned in Nassau County District Court and remanded to the Nassau County Jail on 2/23/12 with $10,000 bond or $5,000 cash bail. He was next scheduled to appear at court on 3/9/12.

5. Ryan was booked into the Nassau County Correctional Center at 2:23 p.m. by Officer M.A. Ryan was screened twice for suicide risk using the Suicide Prevention Screening Guidelines, once by uniformed correctional booking staff and once by a Licensed Practical Nurse employed by Armor, Inc. He scored a "1" on the uniformed staff screening for having a prior psychiatric history, and for taking medications. He was referred to see mental health services and sent to be housed in mental observation on constant supervision. [redacted]

[redacted]

6. [redacted]

7. Ryan was housed on B2, A block, cell #2. Ryan was housed in new admission mental health housing. He was not on constant supervision or suicide watch. An officer is continuously posted on A block and rounds are conducted every 15 minutes.

8. [redacted]

The Board finds this assessment by Dr. V.M. to have been inadequate in not properly accounting for and addressing [redacted]

9. [redacted]

10. Officer T.K. was assigned as the meal relief officer for B2 on 2/24/12 for the 8:00 a.m. to 4:00 p.m. tour. Officer T.K. took over supervision of A block at 2:45 p.m. Officer R.V. was assigned as patrol officer for A and B blocks for the 8:00 a.m. to 4:00 p.m. tour. At approximately 3:00 p.m., Officer T.K. stopped by cell #11 to speak with inmate H.R. Officer R.V. was completing a patrol of blocks A and B at approximately 3:02 p.m. and stopped by cell #11 to speak with inmate H.R. as well.

11. When Officers T.K. and R.V. finished speaking to inmate H.R., they proceeded to the front of the cell block. At cell #2, they observed Ryan hanging from the cell bars by a bed sheet. The officers ran from the tier to notify other officers. Officer R.V. obtained the lock box keys from Officer P.G. and opened the tier. Officer M.V. reported the emergency on his facility radio and then responded as well.

12. Officer T.K. entered into A block. He was unable to get the cell gate opened due to the way Ryan was positioned. Officer T.K. called for a 911 cut down tool and Officer P.G. responded with one. Officer T.K. cut the sheet away from Ryan's neck and Ryan slid downward. The cell gate would still not open after Ryan was cut down as his arm had fallen in between the cell bars. Officers T.K. and P.G. repositioned Ryan through the bars and the gate was then opened. Officer M.V. entered the block and along with Officers T.K. and P.G. removed Ryan from his cell. Ryan was unresponsive and had no breathing or pulse.

13. Officer M.V. began chest compressions on Ryan while Officer T.K. and P.G. worked on establishing an airway and rescue breathing. Officer J.G. responded with an AED and Officer M.V. applied it. No shock was advised.

14. [redacted]

15. During the resuscitation, it was found that an ambulance had not been called for. Officer J.G. called for an ambulance from the East Meadow Fire Department at approximately 3:23 p.m. [redacted]

16. [redacted]

17. In response to this incident, the Nassau County Sheriff directed Correctional Center staff to review policy and procedure CD 06-0404, Public Access Defibrillation, which requires simultaneous activation of EMS and when the AED is deployed.

RECOMMENDATIONS:

TO THE OFFICE OF THE NASSAU COUNTY SHERIFF:

The Office of the Nassau County Sheriff, in accordance with the completed incident review, shall ensure that all staff are familiar and comply with policy and procedure CD 06-0404, Public Access Defibrillation.

TO THE PRESIDENT OF ARMOR, INC.:

1. Armor, Inc. shall conduct a quality improvement training session with all mental health staff on assessing the special mental health needs of combat veterans who are incarcerated.

2. Armor, Inc. shall inquire into and evaluate the professional conduct of V.M., MD, who performed an inadequate psychiatric assessment of a patient [redacted]

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 this 19th day of March, 2013.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:CO:mj
12-M-21
12/12

cc: Jose Armas, M.D., President, Armor Correctional Health Services, Inc.